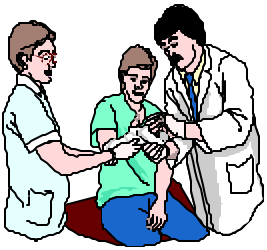
The National Park Service

Employee Injuries/Illnesses

Rights and Responsibilities

Safety All Day Keeps the Doctor Away



Park Operations & Education
Risk Management Division
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This booklet addresses questions and concerns which may arise for employees who have been injured or developed occupational illnesses while in the performance of duty. It is to serve as a handbook for employees who have filed claims for Federal workers' compensation benefits. Also, it provides general information for both employees and agency personnel/supervisors to ensure that our employees receive proper benefits as quickly as possible.

To qualify for benefits, the employee or his/her survivors must establish that the injury or the employee's death was causally related to his or her employment, or that a pre-existing injury or illness was aggravated as a result of the Federal employment.

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Traumatic Injury Claims

A traumatic injury is defined as a wound or other condition of the body caused by external force, including stress or strain. The injury should be identifiable as to time and place of occurrence and member(s) or function(s) of the body affected; it must be caused by a specific event or incident or series of events or incidents within a single day or work-shift. **It is this last criterion which sets apart a traumatic injury from an occupational disease.**

In most cases, traumatic injuries are easy to identify. For example: An employee falls and is cut or breaks a bone. This happens in one single event on one day. The more difficult cases to classify are when an employee incurs a condition that stems from more than one action. For example: a Federal employee is exposed to poison ivy on one day and contacts a rash. Since the exposure happened only in one work shift, this condition would also be classified as a traumatic injury.

In a traumatic injury case, compensation may be claimed for damage to prosthetic devices, medical braces, eyeglasses and hearing aids. In the case of eyeglasses and hearing aids, this is strictly limited to damage caused at the time of the injury and the injury must require medical attention. In other words, if the person does not seek medical treatment, no claim for damaged property can be filed. Personal property claims can only be filed under The Military and Civilian Personal Property Act, 31 USC 240.

The Supervisor Should Proceed as Follows:

1. Provide the employee with Form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation. When an employee sustains a traumatic injury in the performance of duty, he or she would notify the supervisor as soon as possible. Form CA-1 should be completed by the supervisor and employee using the **Safety Management Information System (SMIS)**. Authorize medical care if needed. Promptly complete the front of Form CA-16, Authorization for Examination and/or Treatment. If you doubt whether the employee's condition is related to the employment, you should so indicate on the form. In an emergency, where there is no time to complete a Form CA-16, the supervisor may authorize medical

treatment by telephone and then forward the completed form within 48 hours. As the supervisor, you may refuse to issue a CA-16 if more than a week has passed since the date of injury on the basis that the need for immediate treatment would normally have become apparent in that period of time.

Provide the employee with Form OWCP-1500 which is used for billing.

2. If the employee does not seek medical care, or obtains only agency-sponsored care on the date of injury, and no time loss is charged to either leave or continuation of pay, the supervisor should place Form CA-1 in the worker's Employee Medical Folder instead of sending it to OWCP.

3. Advise the employee of the right to elect continuation of pay (COP) or annual or sick leave if lost time will occur. Inform the employee whether COP will be controverted, and if so, whether pay will be terminated. The basis for the action must be explained to the employee and indicated on Form CA-1 box 36.

4. The employee must submit medical evidence of disability within 10 working days or risk termination of COP.

5. If disability is expected to continue beyond the period of entitlement to COP the employee may claim compensation or use leave to cover absence from work. If the employee chooses not to use sick or annual leave he or she would be carried in a LWOP status. The supervisor, should give Form CA-7, Claim for Compensation On Account of Traumatic Injury or Occupational Disease to the employee on the 30th day of COP with instructions to complete the front and return the form to the agency within one week.

6. An employee who has returned to work but continues to require medical treatment during work hours may claim compensation for lost wages while undergoing or traveling to and from the medical treatment facility. Such a claim may be made on Form CA-7, and should be accompanied by a statement from the supervisor indicating the exact period of time and the total amount of wages lost due to the treatment and the number of hours or days the employee would have worked if available.

7. The supervisor should send Form CA-1 to the appropriate district office of the Department of Labor as soon as possible but no later than 10 working days upon receipt from the employee.

Occupational Disease Claims

The following contains some guidelines and procedures for the Agency when an employee files Form CA-2, Notice of Occupational Disease and Claim for Compensation for possible exposure to chemical spills and other contaminants, smoke inhalation, pulmonary and orthopedic conditions, employment related stress resulting in cardiac, emotional and gastrointestinal conditions, carpal tunnel, hearing loss, skin disease, asbestos related illness, etc., while in the performance of duty.

An occupational disease is defined as a condition produced in the work environment over a period longer than 1 work-day or shift. It may result from systemic infection, repeated stress or strain, exposure to toxins, poisons, or fumes or other continuing conditions of the work environment. In order to qualify as a disease, the injury must be caused by exposure or activities on at least 2 days. **For example:** an employee whose job consisted of moving furniture every day developed back strain. If the back strain came from continued lifting rather than lifting a specific piece of furniture, this case would fall under the occupational disease classification. **Similarly**, an employee who was exposed to toxic fumes over a long period of time and contracts a respiratory disease would fall under the "disease" category.

Sometimes an employee will attempt to file an occupational disease claim for a coronary or psychiatric condition. It is extremely difficult to prove that these conditions were caused by a person's job activities or environment. Coronary and psychiatric claims take longer to adjudicate than traumatic injuries. It must be determined if the circumstances or events constitute factors of employment. In other words, did the events arise out of the employee's regular duties or was it a requirement imposed by the employment or a special assignment? Is there a sufficient nexus between the claimed causative factor and the employment to bring the factor within the performance of duty? Is the disability related to the performance of assigned duties, conditions of employment, or a requirement of the employer. It is the mix of all relevant circumstances which determines whether or not the claimed disability arose out of employment.

Employment related exposure or having a heart attack at work does not necessarily mean that an employee has developed an occupational disease in the performance of duty. A detailed and comprehensive factual statement describing the employment related exposure, heart condition etc., must be furnished by the employee along with a comprehensive medical report that defines the medical condition by providing a diagnosis and connecting it to the claimed exposure. The medical documentation must support causal relationship.

While the employee has the burden of establishing that he or she did in fact develop an occupational illness it is our responsibility to provide the employee with the proper guidance and assistance.

If exposure, coronary conditions, stress related issues or any other occupational related illness results in any of the following:

1. *A medical charge against OWCP (medical bills and related expenses incurred);*
2. *Disability for work beyond the day or shift;*
3. *The need for more than two appointments for medical examination and/or treatment on separate days leading to loss time from work;*
4. *Future disability;*
5. *Permanent impairment.*

The Supervisor Should Proceed as Follows:

1. Provide the employee with Form CA-2, Notice of Occupational Disease and Claim for Compensation. The employee should answer questions 1 through 18 and return to the supervisor.

2. The supervisor should provide the employee two copies of the appropriate checklist, Form CA-35 a-h, Occupational Disease Checklist for the disease or illness claimed. These lists are essential in describing the information needed from both the employee and the Agency in order to have the appropriate OWCP district office adjudicate the claim. One checklist is for the employee to use to gather the necessary evidence to support the claim. The second checklist is for the employee to take to the attending physician. Please be sure to advise the employee to read carefully and follow the instructions on the form. All decisions pertaining to one's claim is made by OWCP of the Department of Labor.

3. Upon receipt of the completed Form CA-2 and any accompanying documentation from the employee, the supervisor (or appropriate official) must complete items 19 through 35 and submit to OWCP within 10 working days of receipt from the employee.

4. Advise the employee of the right to elect sick or annual leave or leave without pay, pending adjudication of the claim.

5. Form CA-7 is used to file an original claim for compensation because of wage loss resulting from an occupational disease. The claim should be filed within 10 days after pay stops or when the employee returns to work, whichever occurs first.

6. Because it takes much longer to adjudicate occupational disease claims, the employee may elect to use sick or annual leave pending the outcome of the claim. If this is done, the employee could repurchase this leave by using Form CA-7 in conjunction with Forms CA-7a (Time Analysis Form) and CA-7b Leave Buy Back Worksheet/Certification and Election. The supervisor must indicate the amount and type of leave used for each day and the employee must provide medical documentation supporting the period of repurchase requested. **Please advise the employee that he or she would have to pay a balance in order to have the leave fully restored. The DOL district office pays the majority and the employee pays the remaining balance.**

Frequently Asked Questions???

1. What is a lost time injury?

The term "lost time injury" means a nonfatal traumatic injury that causes any loss of time from work beyond the day or shift it occurred; or a nonfatal nontraumatic illness/disease that causes disability at any time.

2. What is the Federal Employees' Compensation Act?

The Federal Employee's Compensation Act (FECA) is a law which provides compensation benefits to civilian employees of the United States for disability due to personal injury (including occupational disease) sustained while in the performance of duty. Damage to or

destruction of medical braces, artificial limbs and other prosthetic devices incidental to a personal injury is also compensable. The FECA also provides for the payment of benefits to dependents if job related injury or disease causes the employee's death.

The Act provides compensation for any medical services needed to provide treatment to counteract or minimize the effects of any condition, disease, or injury judged to be causally related to employment with the Federal Government.

3. What is Continuation of Pay (COP) and when does it begin and end? If COP has already been paid to an employee and later OWCP denies claim, what becomes of the COP that has been paid?

COP is the continuation of an employee's regular pay by the agency with no charge to sick or annual leave. Form CA-1 is designed for this purpose and there is no provision for COP in Occupational Disease Claims, Form CA-2. The Federal Employees' Compensation Act, FECA provides that an employee's regular pay may continue for up to 45 calendar days of wage loss due to disability and/or medical treatment after a traumatic injury. Because COP is not considered compensation it is subject to the usual deductions from pay, such as income tax and retirement allotments. After COP ends, the employee may apply for compensation or use leave.

COP only applies in traumatic injuries and Form CA-1 must be completed within 30 days of the date of injury in order to be eligible to receive it. Medical documentation must be provided within 10 days of injury to the agency personnel. However, pay may be continued if the supervisor is satisfied that the employee did in fact sustain a disabling traumatic injury. The period to be charged to COP begins with the first day or shift of disability or medical treatment following the date of injury provided that the absence began within 45 days after the injury. Since COP is paid on calendar days it would include weekends and holidays if the medical evidence shows the employee was disabled on the days in question. For example, if the physician states that disability will continue only through Saturday for an employee who has Saturday and Sunday off, COP will be charged only through Saturday.

In many cases, an employee will return to work without using all 45 days of entitlement of COP. Should such an employee suffer a recurrence of disability, he or she may use COP if no more than 45

days have elapsed since the date of first return to work, including part-time work and light or limited duty (alternative work assignment). If the recurrence begins later than 45 days after the first return to work, the agency should not pay COP even though some days of entitlement remain unused. A period which begins before the 45-day deadline and continues beyond it may be charged to COP as long as the period of time is uninterrupted.

Since there is no provision for COP in occupational disease claims, the employee may use sick or annual leave pending adjudication of the claim. It must be remembered, a claims examiner at the Department of Labor, Office of Workers' Compensation Programs has up to 180 days to adjudicate an occupational disease claim. The employee does not receive monetary compensation for wage loss until the claim has been accepted. Form CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease is used to initiate a claim for monetary compensation because of wage loss. If the employee uses sick or annual leave pending adjudication of the claim, the employee may repurchase that leave by using Form CA-7 (along with Forms CA-7a, Time Analysis and CA-7b, Leave Buy-Back Worksheet).

When OWCP **denies** a traumatic injury claim, the COP that had been paid must be corrected by the employee's timekeeper. For example: an employee who had been paid 80 hours of COP and later the claim was **denied**, the 80 hours of COP would be charged to the employee's sick or annual leave.

4. What is the definition of physician under the FECA?

The term "physician" includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors within the scope of their practice as defined by State law. Naturopaths, faith healers, and other practitioners of the healing arts are not recognized as physicians within the meaning of the law.

5. Is it necessary to report a minor injury which occurs at work, like a scratched finger or bumped knee?

Yes. All injuries should be reported. Many times what we may consider to be a minor injury can develop into a serious complicated condition. For the employee's protection, he or she should file report of the injury and advise the immediate supervisor when it occurs.

6. Are the services rendered by a chiropractor reimbursable under the FECA?

Under the FECA, the services of chiropractors may be reimbursed only for treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist. The term "subluxation" is defined as an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically which must be demonstrable on any x-ray film to individuals trained in the reading of x-rays. Chiropractors may interpret their own x-rays, and if a subluxation is diagnosed, OWCP will accept the chiropractor's assessment of any disability caused by it.

7. Can the injured employee choose the physician who will provide treatment?

An employee is entitled to initial choice of physician for treatment of an injury. He or she may choose any licensed physician in private practice who is not excluded, or he or she may choose to be treated at a government medical facility if one is available. Agency personnel may not interfere with the employee's right to choose a physician, nor may they require an employee to go to a physician who is employed by or under contract to the agency before going to the physician of the employee's choice. Agency personnel **may contact the attending physician** only to obtain additional information about or clarify the employee's duty status or medical progress, and **only in writing.**

8. Can the employee change from one physician to another?

Any changes in treating physicians must be authorized by OWCP except for a referral made by the attending physician. Otherwise, OWCP will not pay for the treatment. The employee must request any such change in writing and explain the reasons for the request.

9. Will OWCP automatically pay for membership in a health club if prescribed by the attending physician?

To guarantee payment, some forms of medical treatment must have prior authorization from OWCP. Such forms of treatment include:

- **Non-emergency surgery; a second opinion examination may be needed before such surgery can be approved.**

- **Private hospital room accommodations. (Only semi-private rooms will be authorized unless the employee's condition requires private accommodations);**
- **Hospital beds, traction apparatus, wheelchairs and similar equipment:**
- **Orthopedic appliances and shoes;**
- **Nursing home care;**
- **Courses of physical therapy;**
- **Hearing aids and lip reading services;**
- **The services of hearing and seeing-eye dogs;**
- **Memberships in health clubs.**

The attending physician must request such services and provide his or her reasons for why such services are needed. However, prior authorization is not necessary for such minor appliances such as a sacroiliac belt or an ankle strap, or for such items as crutches and canes if prescribed by the attending physician.

10. Does the employee have to report for medical examination when directed by OWCP?

Yes. The employee is required to submit to examination by a physician when so requested by OWCP. Failure to do so without adequate reason may result in suspension of compensation or denial of the claim.

11. Is an employee considered to be in performance of duty for compensation purposes 24 hours a day while in travel status?

Employees in travel status are covered 24 hours a day for all reasonable incidents of their temporary duty. Thus, an employee injured on a sightseeing trip in the city to which he or she was assigned would not be covered, while an employee injured while taking a shower in the hotel would be covered. All claims for injuries occurring in travel status should be accompanied by a copy of the travel authorization.

12. What is the procedure if an employee is receiving monetary compensation from OWCP and has to relocate to another state?

The injured employee must advise the responsible claims examiner in writing of the new address and the effective date. This is necessary because in some cases the employee's case file may need to change

jurisdictions and must be transferred to the appropriate servicing District Office which will become responsible for its case management.

13. Should the employee file a claim for OWCP benefits for possible exposure to nuclear waste as a result of inhaling dust particles which may have been contaminated?

We can never prevent an employee from filing a claim under any circumstances. However, the Federal Employees' Compensation Act, FECA does not provide benefits or payment of expenses associated with possible exposure to an infectious agent without the occurrence of a work-related injury. Fear of exposure to an infectious agent does not entitle one to FECA because no injury has occurred. There is a difference between actual exposure as opposed to fear of exposure.

14. How do you document exposure to environmental hazards that may occur on fire assignments?

In documenting exposure to environmental hazards one must be able to provide as much detail as possible to the following questions: To what were you exposed, e.g., smoke, fumes, dust? What was the concentration? Was it visible in the air? How were you exposed? Did you inhale the substance directly? Did you utilize protective equipment such as a respirator or a mask? What tasks did you perform which required the claimed exposure or contact? How often were you exposed? For how long on each occasion? Approximately how many hours per day and days per week? Describe the development of the claimed condition. When did you first notice it? Has it come and gone or has it been present continuously? What symptoms have you experienced? Describe all previous pulmonary conditions and all known allergies. Have you ever had asthma or bronchitis before? Do you smoke cigarettes, cigars or a pipe? How much and for how long have you smoked? If you don't smoke now, have you ever? How much, for how long, and when did you quit? From the agency/supervisor it is necessary to provide the results of any air samples (if available). What levels of concentration are considered safe? What tasks did the employee perform which resulted in the exposure or contact? What was the frequency and duration of exposure? What precautions were taken to minimize effects of exposure (e.g., a mask or respirator)? Providing answers to the above-referenced questions is of necessity and constitutes crucial evidence to document definite exposure to an infectious agent resulting in an occupational illness.

15. How do you code and charge traumatic injuries and occupational illnesses pertaining to wildland fires?

Employees injured while fighting fires, investigating its causes and or working on recovery efforts associated with wildland fires are covered by OWCP and are processed by, and charged to, the employee's home or employing unit, regardless of where the injury or illness occurs.

On the reverse side of the CA-1 or CA-2, the block labeled OWCP Agency Code you should enter **7107** for any regular NPS employee **followed by the two letter alpha code** which further specifies the exact location of the reporting office pertaining to the employee. For example, an employee from Shenandoah National Park would enter **"7107LU"** in the block labeled OWCP Agency Code. **Note:** The two-letter alpha code must be completed prior to submitting the CA-1 or CA-2 to OWCP to ensure accurate chargeback costs. **Code 7157 is only used for non NPS employees.**

Evidence Required In Support of a Claim for Occupational Disease

U.S. Department of Labor
Employee Standards Administration
Office of Workers' Compensation Programs

All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Give a detailed description of factors of employment believed responsible for condition. Be specific as to the duration and nature of the factors: for instance weights carried, distances walked, chemicals used or other relevant job factors.	
2. Give the history of the condition from first awareness of the problem. Include description of all home treatment and professional care as well as symptoms.	
3. Describe any prior similar problem with dates of onset history, medical care received and copies of the medical records of your treatment.	
4. Attach or forward a medical report from your physician to include the following items: a. Dates of examination and treatment. b. History given by you. c. Detailed description of findings. d. Results of all diagnostic tests. e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in item no. 1 above.	

FROM EMPLOYING AGENCY	✔
5. Review and comment on employee's statement provided in response to item no. 1.	
6. If employee's job differs from official description, describe exactly his/her duties.	
7. Give a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Most recent SF-50, Notification of Personnel Action.	

Form CA-35A
Rev. Aug. 1988

Evidence Required In Support of a Claim for Work-Related Hearing Loss

U.S. Department of Labor
Employee Standards Administration
Office of Workers' Compensation Programs

IF YOU ARE FILING A CLAIM FOR HEARING LOSS, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service.	
2. For each job title, describe source of noise, number of hours of exposure per day, and use of any safety devices to protect against noise exposure. State when safety devices were provided.	
3. Give history of any previous ear or hearing problems.	
4. Describe any hobbies which involve exposure to loud noise.	
5. If you are no longer exposed to hazardous noise at work, give the date you were last exposed. If you have been examined or treated by a doctor for an ear or hearing problem, provide a medical report and audiograms.	
6. State whether a claim for workers' compensation benefits for this or any other condition affecting ears or hearing was ever filed. If so, give date of claim, name and address where filed, and benefits received.	
7. Give the date you first noticed your hearing loss. 8. Give date you first related hearing loss to employment, and reason why.	

FROM EMPLOYING AGENCY	✔
9. Review and comment on employee's statement provided in response to questions 1-5.	
10. Describe all work-related exposure to hazardous noise, including: a. Locations of job sites. b. Nature of exposure to noise (machinery, etc.) c. Decibel and frequency level (noise survey report) for each job site. d. Period of exposure, hours per day, days per week. e. Type of ear protection provided.	
11. Attach copies of the employee's: a. SF-171, Application for Employment. b. Job sheet and employment record. c. All medical examinations pertaining to hearing or ear problems, including pre-employment examination and all audiograms.	
12. If the employee is no longer exposed to hazardous noise, give date of last exposure and the payrate in effect on that date.	

Form CA-35B
Rev. Aug. 1988

APPENDIX C **Occupational Disease Checklists**

Evidence Required In Support of a Claim for Asbestosis-Related Illness

U.S. Department of Labor
Employee Standards Administration
Office of Workers' Compensation Programs

If you are filing a claim based on exposure to asbestos, use this checklist to identify the information needed from you and your employing agency. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service **(see attached questionnaire).**	
2. For each job title, describe the work you performed, the type of asbestos material used, locations where exposure occurred, period of exposure, number of hours per day and days of week exposed and the types and frequency of safety precautions (mask, respirator, etc.) used **(see attached questionnaire).**	
3. Describe any exposure you have had to other toxic substances. If none, state "None".	
4. Describe any breathing or lung problems you have had in the past and treatment received **(see attached questionnaire)**.	
5. Give your smoking history to include amount per day, and years (dates) you have smoked **(see attached questionnaire)**.	
6. Submit a report from your physician, including chest x-ray report, history, physical findings, diagnosis, opinion as to the relationship of the condition to employment, and course of treatment.	
7. Give the date you first consulted a physician regarding respiratory or asbestos-related disease.	
8. Submit reports of examination, treatment or hospitalization for any previous condition or pulmonary problem.	

FROM EMPLOYING AGENCY	✔
9. Review and comment on the accuracy of the employee's description of work performed and exposure to asbestos and other substances.	
10. Provide exposure data, including air sample surveys or statements of the type of asbestos exposure, frequency, degree and duration for each job held. Air sample results should be reported in units of fiber/cc time weighted average. Also report concentrations of other pollutants and chemicals **(see attached questionnaire).**	
11. Give the date employee was last exposed to asbestos at work. If the employee was removed from exposure, give the circumstances.	
12. Attach copies of the employee's: a. SF-171, Application for Employment b. Position description with physical requirements for last job held. c. Job sheet and employment record. d. Pertinent dispensary records. e. Most recent SF-50, Notification of Personnel Action. f. Laboratory test results and chest x-ray reports on file.	
13. Describe safety regulations and protective devices in use by employee, with period and frequency of use.	

Form CA-35C
Rev. Oct. 1987

Evidence Required In Support of a Claim for Work-Related Coronary/Vascular Condition

U.S. Department of Labor
Employee Standards Administration
Office of Workers' Compensation Programs

IF YOU ARE FILING A CLAIM FOR CORONARY OR VASCULAR CONDITIONS (for example: heart attack, stroke, hypertension), THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Give a detailed description of the factors of your employment you believe responsible for your condition. Identify dates, periods, events, people involved, etc.	
2. If you are claiming compensation for a heart attack or stroke, provide a specific account of your activities on and off duty for one week prior to the attack, with emphasis on the twenty-four hours immediately preceding the attack.	
3. If you have a prior history of heart problems, provide a description of your condition and copies of medical records of treatment.	
4. Give your smoking history to include amounts and years (dates) you smoked.	
5. Provide a medical report from your physician which includes: a. Dates of examination and treatment. b. History given by you. c. Family history and other risk factors. d. Detailed description of findings. e. Copies of all diagnostic test results. f. Diagnosis. g. The clinical course of treatment followed. h. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in Item no. 1 above.	

FROM EMPLOYING AGENCY	✔
6. Review and comment on the employee's statements in response to questions 1-5.	
7. Describe in detail the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
8. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
9. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
10. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
11. Attach copies of the employee's: a. SF-171, Application for Employment b. Position description with physical requirements. c. Pre-employment medical examination. d. All other pertinent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

Form CA-35D
Rev. Aug. 1988

Evidence Required In Support of a Claim for Work-Related Skin Disease

U.S. Department of Labor
Employee Standards Administration
Office of Workers' Compensation Programs

IF YOU ARE FILING A CLAIM FOR A SKIN CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Give a detailed description of the employment factors you believe responsible for your condition, to include: a. Specific type of exposure. b. Frequency and duration of exposure. c. Protective equipment used to guard against exposure.	
2. Describe any exposure to skin irritants outside the work environment, including the type, duration and frequency of exposure.	
3. Describe any previous skin conditions from the time they began through the present.	
4. Provide treatment records from any physicians who have provided treatment for any skin conditions.	
5. Attach or forward a medical report from your current physician to include: a. History of exposure. b. Findings. c. Diagnosis. d. Details of treatment. e. Explanation of the relationship between the findings and exposure history listed in Item no. 1 above. f. Discussion of temporary vs. permanent effect from work exposure. g. Work restrictions caused by the condition.	

FROM EMPLOYING AGENCY	✔
6. Review and comment on the employee's statements provided in response to questions 1-5. Comment on the exposure claimed, providing any available information about the trade name and/or chemical content of the suspected irritants.	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Copies of all physical examinations on file. e. Most recent SF-50, Notification of Personnel Action.	

Form CA-35E
Rev. Aug. 1988

Evidence Required In Support of a Claim
for Work-Related Pulmonary Illness (not asbestosis)

U.S. Department of Labor
Employee Standards Administration
Office of Workers' Compensation Programs

IF YOU ARE FILING A CLAIM FOR PULMONARY CONDITION NOT RELATED TO EXPOSURE TO ASBESTOS, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Describe the work conditions which caused or aggravated your pulmonary condition; include types of irritants, dates of exposure and hours per day. Describe any safety measures taken.	
2. Explain the development of the present pulmonary condition and treatment from its beginning.	
3. Give your smoking history to include amounts and years (dates) you smoked.	
4. Give the history of previous pulmonary conditions: include dates and nature of illness, and treatment records from all physicians and hospitals where you were treated.	
5. Attach or forward a medical report which includes the following items: a. Dates of examination and treatment. b. History given by you. c. Detailed description of findings. d. Results of all diagnostic tests. e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may have and the factors of employment listed in item no. 1.	

FROM EMPLOYING AGENCY	✔
6. Review and comment on employee's statement provided in response to questions 1-5. Give periods, degree and nature of exposure. Explain safety precautions. Give full details of any tests which were made to determine the concentration of irritants. Have other employees been similarly affected?	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pre-employment medical examination and any other pertinent medical records. d. Most recent SF-50, Notification of Personnel Action.	

Form CA-35F
Rev. Aug. 1988

APPENDIX C **Occupational Disease Checklists**

Evidence Required In Support of a Claim
for Work-Related Psychiatric Illness

U.S. Department of Labor
Employee Standards Administration
Office of Workers' Compensation Programs

IF YOU ARE FILING A CLAIM FOR A PSYCHIATRIC CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Give a detailed chronological description of particular employment factors which you believe caused your condition. Please identify dates, periods, events, people involved, etc.	
2. Describe the progress and development of the work-related condition from its beginning.	
3. Have you previously suffered from this or a similar condition? If so, give details of symptoms, disability and treatment records from all physicians and hospitals where you were treated.	
4. Give a brief description of your personal activities, hobbies, and any other employment.	
5. Describe changes or other sources of stress in your personal life occurring in the same time frame.	
6. Attach or forward a medical report as described on the reverse.	

FROM EMPLOYING AGENCY	✔
7. Review and comment on employee's statements provided in response to questions 1-5. Submit statements from witnesses, if appropriate.	
8. Provide a detailed statement describing the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
9. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
10. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
11. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
12. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pre-employment medical examination. d. All other pertinent medical records available. e. Most recent SF-50, Notification of Personnel Action.	

Form CA-35G
Rev. Aug. 1988

Evidence Required In Support of a Claim
for Work-Related Carpal Tunnel Syndrome

U.S. Department of Labor
Employee Standards Administration
Office of Workers' Compensation Programs

If you are claiming that your carpal tunnel or wrist problems are due to your job, use this checklist to identify the specific information needed from you and your employing agency to make a decision on the claim. All of the following information should be submitted with Form CA-2. Please return the checklist with statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Prepare a statement giving the following information:	
a. Provide an outline of your work history, including non Federal employment and military service. For each job held, give your job title, agency/company name, and dates (period) of employment.	
b. For each job title, describe duties which required exertion with or repeated movement of the wrist or hand. Describe nature and frequency of motions required, and average number of hours a day/week you did such work.	
c. Describe hobbies, physical fitness or other activities outside of work which also involved exertion or repeated motions of wrist/hand. State the nature of each such activity, years involved in each, and how many hours a week you engaged in such.	
d. If you have ever had an injury to the hand/arm/wrist, or been diagnosed as having gout, arthritis, hypothyroidism, diabetes, a tumor, or deformity of the hand/wrist, from/since birth, describe the injury or condition, and state when injury occurred or condition was found.	
e. Give a brief chronological history of your hand/wrist problem. State which hand(s) are affected, when you first experienced problems, nature of the problems and changes over time to present, and dates and nature of medical care obtained.	
2. Ask all doctors who treated you to send us a copy of reports or notes describing the condition, testing, and treatment given.	
3. Ask the doctor currently treating your condition to provide a detailed current medical report to include the following specifics: a. Dates of examinations. b. Complete medical history of condition. c. Medical diagnosis of condition. d. Findings and test results, specifically including: results of Phalen~s and Tinel's Sign tests; physical findings concerning sensation over palmar aspect of first three and one-half digits, and dorsal aspect of end joints of same digits, and any atrophy of the Thenar Eminence; results of nerve conduction velocity, and electromyographic testing. e. Treatment to date and prognosis. f. Reasoned opinion explaining any causal relationship between the condition and your civilian job. It is MOST IMPORTANT that the doctor provide opinion as to the likely nature of the physical effects attributable to specified duties of your Federal job, and explain the medical reasoning which supports the opinion as to cause.	

FROM EMPLOYING AGENCY	✔
1. Review the employee's statement giving the following information:	
a. Comment on the accuracy of the employee's statement describing Federal job duties involving use of hand/wrist.	
b. Provide a day-by-day listing of leave and leave without pay used by the employee due to carpal tunnel/wrist problems.	
c. Give date employee entered on duty in job requiring above duties. Also give the effective date(s) and description(s) of any changes in work assignments due to employee's condition and indicate whether duty changes resulted in changes in pay.	
2. Send us copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements for last job held. c. All available medical records, including report of pre-employment examination. d. SF-50s or equivalent documents for changes in assignment/pay due to condition.	

Form CA-35H
October 1987

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle) | 2. Social Security Number

3. Date of birth Mo. Day Yr. | 4. Sex ☐ Male ☐ Female | 5. Home telephone | 6. Grade as of date of injury Level Step

7. Employee's home mailing address (Include city, state, and ZIP code) | 8. Dependents ☐ Wife, Husband ☐ Children under 18 years ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr. | Time ☐ a.m. ☐ p.m. | 11. Date of this notice Mo. Day Yr. | 12. Employee's occupation

13. Cause of injury (Describe what happened and why)

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

a. Occupation code
b. Type code | c. Source code
OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ b. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ a. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ **Date** _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

Form CA-1
Rev. Apr. 1999

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code) | OWCP Agency Code

OSHA Site Code

ZIP Code

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage ☐ CSRS ☐ FERS ☐ Other, (identify)

20. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

21. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

22. Date of injury Mo. Day Yr.

23. Date notice received Mo. Day Yr.

24. Date stopped work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

25. Date pay stopped Mo. Day Yr.

26. Date 45 day period began Mo. Day Yr.

27. Date returned to work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

28. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 32.)

31. Name and address of third party (include city, state, and ZIP code)

32. Name and address of physician first providing medical care (include city, state, ZIP code)

33. First date medical care received Mo. Day Yr.

34. Do medical reports show employee is employee is disabled for work? ☐ Yes ☐ No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? ☐ Yes ☐ No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work $ Per

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor | Date

Supervisor's Title | Office phone

39. Filing instructions
- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☐ No lost time, medical expense incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

Form CA-1,

Rev. Apr. 1999

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employees' behalf)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg; cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and filed CA-1 within thirty days of the injury, you may be entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, the supervisor is responsible for obtaining the witness statement in item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

36) If the employing agency controverts continuation of pay, state the reason in detail.

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability was not caused by a traumatic injury;

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is not a citizen or a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f) The injury was not reported on Form CA-1 within 30 days following the injury;

g) Work stoppage first occurred 45 days or more following the injury;

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines."

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Form CA-1
Rev. Apr. 1999

Benefits for Employees under the Federal Employees' Compensation act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

(1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continue's the employee's pay, the pay must not be interrupted unless one of the provisions outlined in 20 CFR 10.222 apply.

(2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 45th day of the COP period.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfingurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where directed by OWCP.

(5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue collection remedies. (7) It may be given to a congressional office at the request of the claimant. (8) If the claim involves [illegible] government, and for other purposes required or authorized by law. (9) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior | Title | Date (Mo., Day, Yr.)

*U.S. GPO: 1989-454-845/12764

Form CA-1
Rev. Apr. 1989

Notice of Occupational Disease and Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a. b. and c.

Employee Data

1. Name of employee (Last, First, Middle)

2. Social security number

3. Date of birth Mo. Day Yr.

4. Sex

5. Home telephone

6. Grade as of date of last exposure Level Step

7. Employee's home mailing address (Include city, state, and ZIP code)

8. Dependents
- ☐ Wife, Husband
- ☐ Children under 18 years
- ☐ Other

Claim Information

9. Employee's occupation

a. Occupation code

10. Location (address) where you worked when disease or illness occurred (Include city, State, and ZIP code)

11. Date you first became aware of disease or illness Mo. Day Yr.

12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr.

13. Explain the relationship to your employment, and why you came to this realization

14. Nature of disease or illness

OWCP use - NOI Code

b. Type code | c. Source code

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item 12, explain the reason for the

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication.
I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Date

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

For sale by the Superintendent of Documents, U.S. Government Printing Office Washington, DC 20402

Form CA-2
Rev. Jan. 1997

Official Supervisor's Report of Occupational Disease: Please complete information requested below

Supervisor's Report

19. Agency name and address of reporting office (Include city, state, and ZIP Code) | OWCP Agency Code

OSHA Site Code

ZIP Code

20. Employee's duty station (Street address and ZIP Code) ZIP Code

21. Regular work hours From: : ☐ a.m. ☐ p.m. To: : ☐ a.m. ☐ p.m.

22. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

23. Name and address of physician first providing medical care (include city, state, ZIP code)

24. First date medical care received Day Yr.

25. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

26. Date employee first reported condition to supervisor Mo. Day Yr.

27. Date and hour employee stopped work Mo. Day Yr. Time ☐ a.m. ☐ p.m.

28. Date and hour employee's pay stopped Mo. Day Yr. Time ☐ a.m. ☐ p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr.

30. Date returned to work Mo. Day Yr. Time ☐ a.m. ☐ p.m.

31. If employee has returned to work and work assignment has changed, describe new duties

32. Employee's Retirement Coverage ☐ CSRS ☐ FERS ☐ Other, (Specify)

33. Was injury caused by third party? ☐ Yes ☐ No If "No," go to Item 34.

34. Name and address of third party (include city, state, and ZIP code)

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this Claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of Supervisor (Type or print)

Signature of Supervisor Date

Supervisor's Title Office phone

Form CA-2
Rev. Jan. 1997

INSTRUCTIONS FOR COMPLETING FORM CA-2

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

a) A detailed history of the disease or illness from the date it started.

b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.

c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.

d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)

e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

a) Dates of examination or treatment.

b) History given to the physician by the employee.

c) Detailed description of the physician's findings.

d) Results of x-rays, laboratory tests, etc.

e) Diagnosis.

f) Clinical course of treatment.

g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.

b) Attach copies of all medical reports (including x-ray reports requested above).

b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.

c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.

d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement requested above. co-workers should state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement requested above.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

Item Explanations: Some of the items on the form which may require further clarification are explained below.

14. Nature of the disease or illness
Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

20. Employee's duty station, street address and ZIP code
The street address and zip code of the establishment where the employee actually works.

24. First date medical care received
The date of the first visit to the physician listed in item 23.

33. Was the injury caused by third party?
A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

19. Agency name and address of reporting office
The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

23. Name and address of physician first providing medical care
The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

32. Employee's Retirement Coverage.
Indicate which retirement system the employee is covered under.

Employing Agency - Required Codes

Box a (Occupational Code), Box b, (Type Code), Box c (Source Code), OSHA Site Code
The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Record Keeping and Reporting Guidelines.

OWCP Agency Code
This is a four digit (or four digit two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Form CA-2
Rev. Jan. 1997

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

(1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.

(2) Payment of compensation for total or partial wage loss.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) The information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) The information may also be given to Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an

Receipt of Notice of Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

I was first notified about this condition on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior | Title | Date (Mo., Day, Yr.)

This receipt should be retained by the employee as a record that notice was filed.

Form CA-2
Rev. Jan. 1997

National Park Service

Chargeback Alpha Codes

Park/Office	Alpha	Personnel/Workers' Compensation	Phone
Abe Lincoln Birthplace	HD	Rebeca Thomas	502-358-3137
Acadia	ME	Catherine James	207-288-9561
Agate Fossil Beds	AW	John Kacich	308-436-4340
Alagnak Wild River	KS	Deb Flewelling	907-271-3775
Alaska Support Office	AK	Rebecca Moore	907-257-2412
Allegheny Portage RR	AE	Veronica Smalls	814-886-6113
Amer Memorial Park	MP	Mary Mesa	671-472-7240
Amistad NRA	DR	Lee LeJeune	830-775-7491
Andersonville NHS	AV	Stacey Mathews	912-942-0343
Andrew Johnson	AJ	Opal Coffman	423-639-3711
Antietam NB	AN	Donna Welty	301-432-1648
Apostle Island	AI	Liz Eskola	715-779- 3397 X106
Appalachian NST Land Acq	WV	Heidi Miller	304-263-4943
Appomattox CH	AP	Rose Lessler	804-352-8987 X24
Arches	AR	Brenda Tupek	435-719-2117
Arkansas Post	AY	Pat Grove	870-548-2207
Assateague Island	BE	Karen Burns	410-641-1443 X205
Aztec Ruins	NM	Gayle Lopez	505-334-6174
Badlands	IN	Marsha Huether	605-433-5361 X250
Bandelier	BD	Martin Lavadie	505-572-3861 X506
Bent's Old Fort	LA	Steve Clark	719-383-5010 X22
Big Bend	BB	Brian Shugart	945-477-2251
Big Cypress	NP	Robyn Podany	941-695-2000 X340
Big Hole	WI	Rica Dyas	406-689-3155
Big South Fork	ON	Henrietta B. Upchurch	423-569-2404 X234
Big Thicket	BU	Nellie Martinez	409-839-2691 X240
Bighorn Canyon	FS	Leah Stapp	406-666-2412 X305
Biscayne	HM	Angela Rivers-Ceasar	305-230-1144 X3001
Black Canyon of the Gunnison	BL	Sharon Huber	970-641-2337 X233
Blackstone River Valley	BV	Shirley Scott	401-762-0250
Blue Ridge Pkwy	AS	Carolyn Halloway	828-271-4779 X235

Bluestone NSR	BJ	Gail Vaynes	304-465-6504
Booker T Washington	BW	Connie Mays	540-721-2094
Boston Afr_American	BT	Kenneth Shea	617-223-5108
Boston Harbor Island	BH	Lauren Downing	617-223-8672
Boston NHP	BS	Marsha Boyden	617-242-5612
Boston Support Office	BN	Kenneth Shea	617-223-5108
Brown vs. Board of Educ	BM	Katherine Cushinberry	785-354-4273
Bryce Canyon	BC	Vacant	435-834-5322
Buffalo National River	BR	Jim Gray	870-741-5443
Cabrillo	SD	Terry Petrovich	619-523-4561
Canaveral	TT	Natalie Austin	321-267-1110
Cane River Creole NHP	EZ	Fonce' S. Bates	318-352-0383
Canyon de Chelly	CH	Sarah Blackhorse	520-674-5500
Canyonlands	MB	Brenda Tupek	435-719-2117
Cape Cod NS	SO	Mary Ann Dooley	508-349-5785 X228
Cape Hatteras NS	MN	Tammy Hunt	252-473-2111 X143
Cape Lookout	CP	Donna Tipton	252-728-2250
Capitol Reef	TO	Donita Pace	435-425-3791
Capulin Volcano	CV	Jill Morrow	505-278-2201
Carl Sandburg Home	CS	Ann Staley Vaughan	828-693-4178
Carlsbad Caverns	CA	Diane Reed	505-885-8884
Casa Grande Ruins NM	CJ	Linda Gleason	520-723-3172
Castillo de San Marcos	SA	Shirley Vellis	904-829-6506 X227
Catoctin Mtn Park	CT	Andy Ludwig	301-663-9393
Cedar Breaks	CC	Vanessa Ford	435-772-3256
Central High School		Mary Baber	501-661-1892
Chaco Culture NHP	UT	Gayle Lopez	505-334-6174
Chamizal NM	CZ	Carmen Garcia	915-532-7273 X109
Channel Island	VE	Denise Domian	805-658-5705
Chattahochee Rv NRA	DU	Riana Bishop	770-399-8074 X227
Chesapeake & Ohio	CE	Annette Wetzel	301-713-2208
Chickamauga & Chattanooga	OG	Lisa Nielson	706-866-9241 X110
Chickasaw	OK	Betty Wagner	405-622-3161
Chiracahua	WP	Vacant	520-824-3560
Christiansted NHS	ED	Elizabeth Centeno	340-773-1460
Colonial NHP	YT	Sue Cooper	757-898-2405

Colorado NM	CG	Beverly Ward	970-858-0372
Columbia Cascades Suppt Ofc	UM	Jackie Godfrey	206-220-4064
Congaree Swamp NM	HL	Quentin Goodson	803-776-4396
Coronado NM	NF	Queta Ramirez	520-366-5515
Cowpens NB	CW	Michelle Lester	864-461-2828
Crater Lake	CL	Dave Fuller	541-594-2211 X517
Craters of the Moon	CM	Lorrie Fuller	209-527-3257 X104
Cumberland Gap NRA	KY	Diane Simpson	606-248-5766
Cumberland Island NS	SM	Julie Meeks	912-882-4702
Curencanti	CN	Sharon Huber	970-641-2337 X233
Cuyahoga NRA	OH	Loretta Sharif	440-546-5918
Dayton Aviation Heritage	DY	Samartra Anderson	937-225-7705
Death Valley	DV	Mary Davis	760-786-3274
Delaware Water Gap NRA	DZ	Nancy Bruce	570-588-2456
Denali	DN	Bill Allen	907-683-9504
Denver Service Center	DE	Nancy Sundermeier	303-969-2749
DeSoto	DS	Sheri Jackson	941-792-0458 X12
Devil's Tower	WY	Christopher Moos	307-467-5283
Dinosaur	DI	Rebecca Snavely	970-374-3000
Edgar Allen Poe	EA	Carol Avent	215-597-7126
Edison	WO	Linda Deveau	973-736-2550
Effigy Mounds	EF	Friday Wells	319-873-341
El Malpais	EM	Sari Stein	505-285-4641 X16
El Morro	RA	Sari Stein	505-285-4641 X16
Eleanor Roosevelt	ER	Deanne Kette	845-229-9115
Eugene O'Neill	EO	Donna Delgadillo	925-943-1531
Everglades	EV	Dawn Newman	305-242-7727
Farmington Scenic River	FG	Kenneth Shea	617-223-5018
Fire Island	PA	Maria Solano-Brown	631-289-4810 X238
FLETC GLYNCO	GY	Jacqueline Brown	202-619-7001
Florissant Fossil Beds	FL	Sheryl Sether	719-748-3253
Fort Caroline	JA	Debra Lacoste	904-221-7567 X11
Fort Clatsop	FC	Betty Runnels	541-861-2471
Fort Davis	FD	Regina Heiner	915-426-3225
Fort Donelson	DO	Judy Bagsby	931-232-5348
Fort Frederica	FF	Nita Lee	912-638-3639

Fort Laramie	FT	Peggy Amoitte	307-837-2221
Fort Larned	FJ	Andrea Messam	316-285-6911
Fort McHenry	FM	Cecelia Neugebauer	410-962-4290
Fort Necessity	NB	Veronica Smalls	814-886-6113
Fort Pulaski	SV	Jimmy Stafford	912-786-4086
Fort Scott	FY	Mary Beth McClure	316-223-0310
Fort Smith	FI	Chuck Shoemake	501-783-3961
Fort Stanwick	FW	Sonja Wray-Brewer	315-336-2090
Fort Union	FU	Debbie Archuleta	505-988-6888
Fort Vancouver	FV	Elaine Huff	360-696-7655 X12
Fossil Butte	FE	Liz Parker	307-877-4455
Franklin Law Olmstead NHS	OS	Frank Alvarez	617-566-1689 X209
Fredericksburg	FR	Donna Kemp	540-654-5493
Friendship Hill	FN	Veronica Smalls	814-886-6113
Ft Sumter NM	SI	Sherry Webster	843-883-3123 X12
Ft Union Trading Post	WL	Harriet Carico	701-572-1776
Gateway NRA	BK	Dana Taylor	718-338-3844
Gauley River NRA	GV	Gail Vaynes	304-465-6504
Geo Washington Birthplace	WA	Linda George	804-224-1732
Geo Washington Carver	GW	Leslie Saddler	417-325-4151
Geo Washington Pkwy	MC	Marlene Doty	703-289-2500
George Rogers Clark	VC	Leo Finnerty	812-882-1776
Gettysburg	GE	Joan Howard	717-334-1576
Gila Cliff Dwellings	DM	Susan Kozacek	505-536-9461
Glacier Bay	GB	Teresa Wilson	907-697-2634
Glacier NP	WG	Lisa Towery	406-888-7878
Glen Canyon	GL	Yvonne Steward	520-608-6200
Gloria Dei Church NHS	GD	Carol Avent	215-597-7126
Golden Gate NRA	FO	Winnie Fong	415-561-4772
Golden Spike	BG	Kathleen Gonder	435-471-2209
Grand Canyon	GC	Keri Wier	520-638-7723
Grand Portage	GM	Rosalie Kirmse	218-387-2788
Grand Teton	MO	Linda McHuron	307-739-3300
Grant-Kohrs Ranch	DL	Anita Dore	406-846-3388
Great Basin	BA	Amy Williams	775-234-7331 X204
Great Egg Harbor	EG	Judy Knight	215-597-9263

Great Sand Dunes	MS	Virginia Reams	719-378-2312
Great Smoky Mountains	GA	Cathy Clifton	423-435-1309
Guadalupe Mountains	GU	Vacant	915-828-3251
Guilford Courthouse	GI	Angela Fitzgerald	336-288-1776 X22
Gulf Islands	GF	Nancy Wilson	850-934-2611
Hagerman Fossil Beds	HN	Dena Easterday	208-837-4793
Haleakala	HA	Mele Fong	808-572-4410
Hampton NHS	TN	Cecelia Neugebauer	410-962-4290 X228
Harpers Ferry Center	HC	Julie Johnston	304-535-6489
Harpers Ferry JCC	HJ	Brenda Kacinec	304-728-5732
Harpers Ferry NHP	HF	Melinda Sease	304-535-6044
Harry Truman NHS	HB	Joanne Six	816-254-2720
Hawaii Volcanoes	VN	Amy McClelland	808-985-6006
Herbert C Hoover	HH	Deb Patty	319-643-2541
Historic Pres Ctr	HR	Julie Johnston	304-535-6489
Home of FDR	HY	Deanne Kette	845-229-9115
Homestead	HT	Susan Cook	402-223-3514
Hopewell Culture	CE	Bonnie Murray	740-774-1126
Hopewell Furnace	EL	Dawn Dilliplaine	610-582-8773
Horace Albright Training Ctr	AL	Kathleen Gonder	520-638-7987
Horseshoe Bend	DA	Allice Faye Johnson	256-234-7111
Hot Springs	HO	Mary Baber	501-624-3383 X620
Hovenweep	HV	Brenda Tupek	435-719-2117
Hubbell Trading Post	HU	Alberta Shorty	520-755-3475
Ice Age NST	IC	Jan Lee	608-441-5611
Ill & Michigan Canal	IM	Violet Hampton	217-492-4241 X235
Independence NHP	PH	Carol Avent	215-597-7126
Indiana Dunes	PI	Terry Martin	291-926-7561 X441
Intermountain Region	IU	Judy Schnittiker	303-969-2749
Intermtn Cultural Rsch Ctr	IT	Delia Cisneros	505-988-6065
Isle Royale	IR	Sara Rambo	906-487-7143
James A Garfield	JG	Loretta Sharif	440-546-5917
Jamestown NHS	JT	Sue Cooper	757-898-2404
Jean LaFitte	NO	Lynette Harrison	504-589-3882 X104
Jefferson Expansion	JE	Kathleen Adams	314-655-1600
Jewel Cave	JC	Denise Stewart	605-745-1121

Jimmy Carter NHS	JI	Stacey Mathews	912-924-0343
John Day Fossil Beds	JD	Pattie Paul	541-987-2333
John F Kennedy	JK	Kenneth Shea	617-223-5018
John Muir	JM	Donna Delgadillo	925-228-8860
John Quincy Adams NHS	QU	Carol Lee Wilson	617-773-1177
Johnstown Flood Mem	JF	Veronica Smalls	814-886-6113
Joshua Tree	TW	Becky Patterson	760-367-5511
Kalaupapa	KP	Lucy Whiting	808-567-6802 X21
Kaloko-Honokohau	KK	Linda Underwood	808-329-6881
Kenai Fjords	KF	Beth Lowphian	907-224-3175
Kennesaw Mountain	KN	Nancy Milton	770-427-4686
Keweenaw	KH	Rodney Larsen	906-337-3168
Kings Mountain	KM	Debra Ledford	864-936-7921
Klondike Gold Rush	KL	Evelyn Meyer	907-983-2921
Klondike Gold Rush Seattle	KG	Sue Keifer	206-553-7220
Knife River Villages	KR	Pam Thompson	701-745-3300
Lake Clark Katmai NP	KA	Debra Flewelling	907-271-3775
Lake Mead	BO	Shirley Culpepper	702-293-8929
Lake Meredith NRA	LM	Roceythia Pollard	806-857-3151
Lake Roosevelt	CD	Faye Steinhaus	509-633-9441 X120
Lassen Volcanic	MI	Paul Sheehan	550-595-4444 X5142
Lava Beds	TU	Mike Flanagan	530-667-2782 X225
Lewis & Clark NHT	LW	Vacant	402-221-3471
Lincoln Boyhood NM	LI	Vacant	812-937-4541
Lincoln Home	LH	Violet Hampton	217-492-4241 X235
Little BigHorn Battlefield	LT	Prudence Pretty On Top	406-638-2621 X120
Little River Canyon NRA	LR	Mary Jo Blevins	256-495-2672
Long Distance Trails Santa Fe	LS	Jerri Striegler	210-868-7128 X225
Long Distance Trails SLC	LD	Teresa Bichard	801-539-4095
Longfellow	LF	Kenneth Shea	617-223-5018
Lowell NHP	LO	Catherine Burkhart	978-275-1716
Lyndon B Johnson	LJ	Debbie Gibson	830-868-7128 X267
Mammoth Cave	MA	Jackie Johnson	270-749-8309
Manassas	MH	Donna Thompson	703-361-7996
Manhattan Sites	YC	Linda Richardson	212-825-6870
Marsh-Billings Rockefeller	WD	Mea Arego	802-457-3368 X11

Martin Luther King	ML	Cheryl Shropshire	404-331-5190 X3010
Martin Van Buren	KI	Mary Bates	518-758-9689
Mather Trng Ctr (WV)	HW	Julie Johnston	304-535-6211
McLoughlin House NHS	MG	DELETE	Part of Ft. Vancouver
Mesa Verde	MV	Elaine Simo	970-529-4465
Midwest Arch Center	LN	Joyce Hawthorne	402-437-5392 X121
Midwest Region	OM	Carol Solnosky	402-221-3386
Minute Man	CO	Linda Longley	978-369-6944
Mississippi NRA	IP	Denise St Marie	651-290-4160
Missouri NSR	OU	Laurie Wise	402-336-3970
Mojave Npres	MJ	Melissa Heiser	760-255-8812
Montezuma Castle	ZC	Kate James	520-567-5276
Moore's Creek	MK	Hattie Squires	910-283-5591
Morristown	MT	Norman Marcocci	973-539-2016
Mt Rainier	MR	Patty Klump	360-569-2211 X2363
Mt Rushmore	KE	Denise Stewart	605-745-1121
Natchez NHP	NZ	Amy Smith	601-442-7049 X11
Natchez Trace Pkwy	NT	Ron Anderson	662-680-4025
National Capital Region	SW	Karlyn Payton	202-619-7247
Natl Captl Parks-East	SE	Matthew Shifflett	202-690-5185
Natl Cptl Parks-Ctrl	NA	Connie Joy	202-485-9869
Natl Interagency Fire Ctr	IA		
Natl Park of American Samoa	AO	Onolina V. Fuamatu	684-633-7082
Natural Bridges	LP	Brenda Tupek	435-719-2117
Navajo	NV	Irv Francisco	520-672-2366
New Jersey Coast Herit Trl	NJ	Deborah Baughman	856-447-0103
New Orleans Jazz	JZ	Mary Martinez	504-589-4806 X26
New River Gorge	GJ	Gail Vaynes	304-465-6504
Nez Perce	NE	Kathy Tustanowski-Marsh	208-843-2261 X112
Nicodemus	ND	Sharyl Cyphers	620-285-6911
Ninety Six	NI	Michele Lester	864-461-2828
Niobrara NDR	NN	Laurie Wise	402-336-3970
North Cascades	NC	Pat Blunt	360-856-5700 X356
North Country NST	WZ	Janice Lee	608-441-5610
Northeast Region	NR	Judy Knight	215-597-9263
Obed Wild & Scenic River	WT	Barbara Olmstead	423-346-6294

Ocmulgee	OE	Debbie Boyd	912-752-8257
Oconaluftee JC Cntr	OF	Edna Higginbotham	828-497-5411
Ofc of White House Liaison	YJ	Diane Burg	202-619-7333
Oklahoma City NM	OA	Marcus Banks	405-235-3313
Olympic	OL	James Kirkland	360-452-4501 X209
Oregon Caves	OC	Kelly Donley	541-592-2100
Organ Pipe Cactus	OP	Shirley Schlinkmann	520-387-6849
Ozark Natl Scenic Rvrwy	OZ	Donna Reynolds	573-323-4336 X251
Pacific Is Sppt Office	HI	Lea Scow	808-541-2693
Pacific Great Basin SO	PF	Maria Davila	415-220-4262
Padre Island	PD	Jeannie Goff	361-949-8173
Palo Alto Battlefield	PT	Oralia Fernandez	956-541-2785
Pea Ridge	PR	Judy Bachlor	501-451-8122
Pecos	PC	Loretta Lujan	505-757-6414 X221
Perry Victory	PB	Jeanne Burgess	419-285-2184
Petersburg	PE	Glenda D. Jenkins	804-732-3571
Petrified Forest	AZ	Ferral Knight	520-524-6228
Petroglyph	PG	Catherine Lopez	505-899-0205 X225
Philadelphia Support Office	PL	Judy Knight	215-597-9263
Pictured Rocks	MM	Teri Perry	906-387-2607
Pinnacles	PN	Lori Fruestia	831-389-4485 X227
Pipe Spring NM	PZ	Vanessa Ford	435-772-3256
Pipestone	PS	Sylvia Voyt	507-825-5464
Point Reyes	PO	Sandi LeFevre	415-663-8522 X367
Poverty Point	PV	Lynette Harrison	504-589-3882 X104
Presidio-San Francisco	PM	Ralph Dodge	415-561-5193
Prince William Forest Park	TR	Karen Brantner	703-221-2391
Pu'uhonoa o Honaunau	PU	Lisa Medeiros	808-328-2326
Puukohola Heiau	KW	Lorna Akima	808-882-7218
Redwoods	CR	Tauna Clausen	707-464-6101 X5021
Richmond NBP	RI	Jessie Stowe	804-226-1981
Rock Creek Park	RO	Alberta Newman	202-282-7601
Rocky Mountain	EP	Janice Leons	970-586-1206
Roger Williams	RW	Shirley Scott	401-762-0250
Roosevelt Vanderbilt	HP	Deanne Kette	914-229-9115
Russell Cave	RC	Mary Jo Blevins	256-495-2672

Sagamore Hill	OB	Monica Boyd	516-922-4271
Saguaro	SN	Amy Osieth	520-733-5106
Saint Gaudens	SG	April May Gelineau	603-675-2701
Salem Maritime	SL	Celia Stevens	978-740-1685
Salinas Pueblo Missions NHS	UE	Kyla Ellsbury	505-847-2585
Salt River Bay NHP	VG	Elizabeth Centaro	340-773-1460 X21
San Antonio Missions NHP	TX	Karen Steed	210-534-8875
San Francisco Maritime	RM	Mariah Cribben	415-556-0817
San Juan Is NHP	JU	Maureen Briggs	360-378-2240
San Juan NHS	SJ	Lissy Mercado	787-729-6777
Santa Fe Sppt Ofc	SF	Delia Cisneros	505-988-6065
Santa Monica Mts NRA	TF	Steve Deboutez	805-370-2319
Saratoga NHP	ST	JoAnn Bielkiewicz	518-664-9821 X205
Saugas Iron Works NHS	IW	Celia Stevens	978-740-1680
Scotts Bluff NM	LG	John Kacich	308-436-4340
SE Archeol Ctr	EH	Janice Burke	850-580-3011
SE Land Acq Office	DJ	Ann Talley	941-261-4477
Sequoia/Kings Canyon	TH	Emily Treece	209-565-3755
Shenandoah	LU	Debbie Truax	540-999-3479
Shiloh NMP	SH	Lisa Casteel	901-689-5275
Sitka NHP	SK	Virginia Hirayama	907-747-6281
Sleeping Bear Dunes	SB	Gail Purifoy	231-326-5134
Southeast Region	AT	Michelle Jackson	404-562-3167 X543
Southern Arizona Ofc	SZ	Sara Quirarte	602-640-5250
Springfield Armory	SY	Albert Kagler	413-734-6477
St Croix Is Intl Hist Site	IE	Catherine James	207-288-9561
St Croix NSR	SR	Anne Adams	715-483-3284 X603
Statue of Liberty	NY	Jackie Martinez	212-363-3206 X115
Steamtown NHS	SC	Maria Havrilla	570-340-5187
Stones River NB	MU	Teresa Watson	615-893-9501
Sunset Crater	SU	Nancy Schultz	520-526-1157 X224
Tallgrass Prairie N Pres	TA	Anne-Marie Rizzi	316-273-6034
Theo Roosevelt NP	MD	Pam Thompson	701-623-4466
Timpanagos Cave NM	AF	Helen Carson	801-756-5239
Timucuam Ecol/Hist Prsv	TM	Debbie LaCoste	904-221-5568
Tonto	RT	Lupe Carrasco	520-467-2241

Tumacacori NHP	TZ	Patricia Tanori	520-398-2341
Tuskegee Inst NHS	TS	Shirley Streeter	334-727-6390
Ulysses S Grant	UL	Kathleen Adams	314-655-1600
United States Park Police	PP	Jacqueline Brown	202-619-7001
USS Arizona Mem	AM	Patricia Moriyasu	808-422-2771 X113
Valley Forge	VF	Stacy R. Browning	610-783-1043
Vanderbilt Mansion	VM	Deanne Kette	845-229-9115
Vicksburg NMP	VB	Shirley Smith	601-636-0583 X8016
Virgin Is	VI	Mindy Silva	340-776-6201 X258
Voyageurs	IF	Lynn Lufbery	218-283-9821
W H Taft	CI	Charlotte Morris	513-684-3262
Walnut Canyon NM	WC	Nancy Schultz	520-526-1157 X224
War in the Pacific NHP	AG	Mary Mesa	671-472-7240
Washita Battlefield	WE	Sara Craighead	580-497-2742
WASO	AQ	Kerrie Skinner	202-208-4581
Weir Farm	WF	Bob Fox	203-544-9829 X10
Western Arch/Consv Ctr	TC	Vacant	520-670-6501
Western Artic Park Lands	KZ	Julie Hopkins	907-442-8303
Whiskeytown NRA	WH	Rudy Maich	530-242-3403
White Sands	WS	Sharon La France	505-679-2599
Whitman Mission	WM	Gloria LaFrance	509-522-6360
Wilson's Creek NB	RP	Paula Velten	417-882-9144
Wind Cave	HS	Denise Stewart	605-745-1121
Wolf Trap Farm	VA	Linda Shearer	703-255-1814
Women's Rights	SS	Kenneth Shea	617-223-5108
Wrangell-St. Elias NP	WR	Michelle Masters	907-822-7224
Wupatki	WU	Nancy Schultz	520-526-1157 X224
Yellowstone	YE	Joanne Timmons	307-342050
Yorktown Natl Cem	YX	Sue Cooper	757-898-2404
Yosemite	YO	Cindy Whitten	209-379-1878
Yukon-Charley/Gates	GS	Robin Burch	907-456-0496
Zion	SP	Vanessa Ford	435-722-3256